QUARTERLY REPORTING REQUIREMENTS

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QUARTERLY REPORTING REQUIREMENTS

PREFACE 8001

Section 443.32 of the Health and Safety Code requires hospitals to report specified summary financial and statistical data. Quarterly financial and utilization reports must be submitted by all hospitals for each calendar quarter beginning on or after January 1, 1986. A form will be mailed to each facility approximately two weeks after the end of each calendar quarter.

Section 90741, Title 22, of the California Code of Regulations, was amended in October 1993 to require all hospitals to submit the Office's Quarterly Financial and Utilization Report in a standard electronic format, as defined by the Office, rather than using hard-copy report forms. Effective with calendar quarters beginning on or after January 1, 1994, quarterly reports must be prepared using the Office-provided Hospital Quarterly Reporting System (HQRS) software and submitted by modem to the Office's Bulletin Board System (BBS). The HQRS software does not support personal computer (PC) diskette reporting. This means that hospitals must have access to an IBM-compatible PC with a Hayes-compatible modem to submit quarterly reports electronically.

Section 97050, Title 22, of the California Code of Regulations allows hospitals to file a request for modification to the Office's electronic quarterly reporting requirements if meeting these requirements is not cost-effective for the hospital. Such requests, if approved, would require the requesting hospital to submit the quarterly reports to the Office on hard-copy report forms.

The quarterly financial and utilization report must be completed and submitted to the Office within 45 days after the end of each calendar quarter. In order to be considered complete, all required items must be completed in accordance with the instructions and shall conform to the uniform description of accounts contained in this Manual. Any hospital which does not file the summary financial and utilization report completed as required is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of such report with the Office is delayed, considering all extension days granted by the Office.

Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal year.

All reports must be submitted to the:

Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
818 K Street, Room 400
Sacramento, CA 95814

This chapter contains a copy of the quarterly report form and instructions.

QUARTERLY REPORTING REQUIREMENTS

GENERAL INSTRUCTIONS FOR COMPLETING QUARTERLY REPORT 8100

The following rules apply to completing and submitting the quarterly financial and utilization report form for calendar quarters beginning on or after January 1, 1994:

1. The quarterly report must be transmitted by modem to the Office's Bulletin Board System (BBS) within 45 days after the close of each calendar quarter. This requirement also applies to hospitals that had a change in licensee, closed, or relocated to a new facility during the quarter. In the event the report is due on a Saturday, Sunday, or Holiday, the report may be transmitted by modem on the next business day. Failure of the hospital's modem to successfully transmit the report or of the Office's BBS to successfully receive a report does not affect the report due date.

   The Electronic Quarterly Reporting Certification must be completed and filed with the Office before the initial quarterly report is transmitted by modem. Additional certifications are not required unless the individual who signed the certification is no longer authorized to accept responsibility for the report.

2. Neither the Office's standard report form nor the HQRS-produced Facsimile Report will be accepted unless prior written approval has been granted by the Office. If approved, a reproduced copy of the report is acceptable if legible and includes an original signature. For your convenience, the Office will accept approved hard-copy reports transmitted by telecopier (FAX No. 916-323-7675) if the certification is signed. Reports which are not legible will be returned for recopying. The original report will be requested if the faxed report is not legible. The original report is not required if it has already been sent by telecopier.

3. In order to be considered complete, the report must be correctly filled out in accordance with the instructions herein and in conformance with the definitions of the account descriptions contained in this Manual.

4. All amounts shall be reported to the nearest dollar. Rounding amounts to the nearest ten, hundred, or thousand is not acceptable.

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5. Any hospital which does not file the report completed as required is liable for a civil penalty of one hundred dollars ($100) a day for each day the filing of such report with the Office is delayed, taking into account any extensions granted as provided in Section 97051, Chapter 10, Title 22, California Code of Regulations.

6. Partial quarter reports must be filed by hospitals which have been in operation for less than one quarter at the end of the first calendar quarter of their operation. The first calendar quarter may be less than three months.

7. When the license of the hospital changes during the calendar quarter, a quarterly report must be filed with the Office by the former licensee for the period of their licensure, and a report must be filed by the new licensee for their first and subsequent calendar quarters. Both reports must be submitted within 45 days after the end of the calendar quarter in which the licensure change occurred.

8. Since all quarterly reports are for calendar quarters, changes in fiscal year end dates will not impact quarterly reporting. Facilities using a 13-period accounting cycle must file a modification request and obtain prior approval from the Office before submitting data based on these accounting periods.

9. The HQRS software will not allow line or column descriptions to be changed under any circumstances.

10. Revisions to prior quarterly reports may be transmitted by modem, submitted using the HQRS-produced facsimile report, or submitted on the Office's standard report form for the calendar year in which the quarter occurred. For example, a revision to the report for the second quarter of 1992 should be submitted on a 1992 quarterly report form.

    Instructions for submitting revisions using the HQRS software are located in Appendix F, HQRS User Guide. If using the Office's standard report form to make revisions, indicate the quarter being revised by checking the appropriate line in column 3 for lines 15 through 20 (1992 and after) or lines 10 through 15 (pre-1992).

    If a prior year report form is not available, you may submit a reproduced copy of the hospital's quarterly report being revised and indicate the changes in red. You may also submit requests for revisions in letter format.

11. Hospitals that receive the preponderance of their revenue from associated comprehensive group-practice prepayment health care service plans and are operated as units of a coordinated group of health facilities under common management may provide financial data for lines 100 through 185 on a group basis. However, such hospitals are encouraged to report line 100, Total Operating Expenses, for each hospital.

DETAILED INSTRUCTIONS FOR COMPLETING QUARTERLY REPORT 8200

1. Enter in item 1 the name under which the hospital is doing business. This may be the hospital's legal name.

2. The HQRS software will enter the OSHPD Facility Number in item 2. This nine digit number begins with "106" and is assigned by the Office for reporting purposes.

3. In items 3, 4, and 5, enter the hospital street address, city, and zip code, respectively.

4. Enter in items 6 and 7 the name and complete phone number of the person who completed the report. This person will be contacted by the Office if there are any questions about the report and will be mailed a blank report form for the next reporting period approximately two weeks after the end of the next calendar quarter.

5. Enter in items 8 and 9 the name of the chief executive officer (administrator) and the hospital's main business phone number.

6. Enter in item 10 the complete phone number of the hospital's disaster coordinator. This individual is responsible for coordinating the hospital's disaster preparedness programs.

7. The reporting software has been designed for full or partial calendar quarters and for either original or revised data. The HQRS User Guide provides detailed instructions on how to submit full and partial reports.

   If you have been pre-approved to submit the Office's standard report form, and if the report is for a full calendar quarter, check the appropriate line in column 2 or column 3 for the quarter being reported. Check column 2 if the report is an original report or

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column 3 if the report is a revised report. Revised reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal year.

If the report period is for more or less than an actual calendar quarter, enter the beginning date of the reporting period on line 19, column 1, and the ending date of the reporting period on line 20, column 1, and check column 2 or column 3 as appropriate.

8. For lines 20 through 200, enter the appropriate financial and utilization data pertaining to the quarter being reported.

   NOTE: If you have been granted permission to file a quarterly report based on your 13-period accounting cycle, be sure that utilization data are also provided for the same reporting period.

9. Enter on line 25 the number of licensed beds (excluding bassinets) stated on the facility license as of the last day of the reporting period. Do not include licensed beds placed in suspense.

10. Enter on line 30 the average number of available beds (excluding bassinets) during the reporting period. Available beds are defined as the daily average complement of beds physically existing and actually available for overnight use, regardless of staffing levels. Do not include beds placed in suspense or in nursing units converted to uses other than inpatient overnight accommodations which cannot be placed back into service within 24 hours.

    The number of available beds may be and often is less than the number licensed. On occasion, such as pending license application for a new inpatient service or when placing licensed beds into suspense, the average number of available beds for the reporting period may exceed the number of licensed beds at the end of the reporting period.

11. Enter on line 35 the daily average complement of beds fully staffed (excluding bassinets) during the quarter. Staffed beds are those beds set up, staffed, equipped and in all respects ready for use by patients remaining in the hospital overnight. The number of staffed beds is usually less than the number of available beds, since hospitals typically staff for those beds currently occupied by inpatients, plus an increment for unanticipated admissions.

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12. Enter on lines 41 through 49 by payor (Medicare, Medi-Cal, County Indigent Programs, Other Third Party Payors, and Other Payors) the number of hospital discharges from all Daily Hospital Services cost centers, including Long-Term Care (LTC) patients discharged during the reporting period. The HQRS software will enter on line 50 the sum of lines 41 through 49. These are the total number of discharges as defined in Section 4120 of the Manual. Do not include newborns discharged from the nursery.

    Discharges are to be reported by primary payor, or that payor who is responsible for the predominant portion of the patient's bill. The primary payor may be different than the expected source of payment at the time of discharge. Do not allocate discharges by payor based on the ratio of patient (census) days or gross inpatient revenue.

    See Section 4120 of the Manual for more information on the definition of a hospital discharge.

    The County Indigent Programs category includes indigent patients covered under Welfare and Institution Code Section 17000. Also included are patients paid for in whole or in part by the County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP or tobacco tax funds), and other funding sources for which the hospital renders a bill or other claim for payment to a county. This category also includes indigent patients who are provided care in county hospitals, or in certain non-county hospitals where no county-operated hospital exists, whether or not a bill is rendered.

    The Other Third Party Payors category includes all other contractual purchasers of health care. Examples include HMOs, PPOs, Short-Doyle, Tricare (CHAMPUS), IRCA/SLIAG, California Children's Services, commercial insurance, and Workers' Compensation. Also included are patients enrolled in managed care HMOs funded in whole or in part by Medicare and Medi-Cal. Do not report the financial and utilization data related to these patients in the Medicare and Medi-cal payor categories.

    The Other Payors category includes all patients not sponsored by any form of coverage, such as those designated as self-pay and those determined to be eligible for charity care. Also included are U.C. teaching hospital patients who are provided care with Support for Clinical Teaching funds.

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13. Enter LTC Discharges for the reporting period on line 55. This is an optional item. Hospitals which provide skilled nursing care, intermediate care, transitional inpatient care (SNF Beds), sub-acute care, and other long-term care services are encouraged to report LTC Discharges so that comparable average lengths of stay can be calculated. LTC also includes skilled nursing care provided in swing beds.

14. Enter on lines 61 through 69 the number of census patient days by payor for all Daily Hospital Services cost centers, including LTC patient (census) days, for the reporting period. Count the day of formal admission, but not the day of discharge as a patient (census) day. Count as one day, each patient formally admitted and discharged on the same day. Do not include newborn days or purchased inpatient days. Do not allocate patient (census) days by payor based on the ratio of discharges or gross inpatient revenue. On line 70, the HQRS software will enter the sum of lines 61 through 69.

15. Enter LTC Patient (Census) Days for the reporting period on line 75. This is an optional item. Hospitals which provide long-term care services, as defined in step 13, and reported LTC Discharges on line 55, are encouraged to report this item.

16. Enter on lines 81 through 89 the number of outpatient visits by Section 4130 of the Manual provides detailed definitions for all outpatient visits. Please refer to Section 4130 to assure that all outpatient visit information is being properly recorded and reported.

17. Enter Total Operating Expenses on line 100. This amount consists f all operating expenses incurred by the hospital for the reporting period accrued to the end of the reporting period. This includes daily hospital services, ambulatory services, ancillary services, purchased inpatient services, research, education, general services, fiscal services, administrative service, and other unassigned costs. If the physicians' professional component (all amounts paid to

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hospital-based physicians and residents for patient care) is recorded as an expense, it must be included in this amount. Non-operating expenses and provisions for income taxes are excluded. Do not reduce operating expenses by Other Operating Revenue.

18. Line 110, Physicians' Professional Component Expenses, is an optional reporting item. However, hospitals are encouraged to report this amount as it will allow a better indication of the change in Total Operating Expenses. Enter on line 110 the physicians' professional component (PPC) expenses included in the physicians' total compensation. This includes all amounts paid or to be paid to hospital-based physicians and residents for patient care and recorded as an expense of the hospital for the reporting period.

19. Enter Gross Inpatient Revenue by payor on lines 121 through 129. These amounts are the total inpatient charges, including PPC charges, at the hospital's full established rates for services rendered and goods sold to inpatients during the reporting period. It includes daily hospital services, inpatient ambulatory services, and inpatient ancillary services. The amounts reported by payor are to be from either the general ledger or payor logs, whichever provides the most accurate data related to the primary payor. The HQRS software will enter the sum of lines 121 through 129 on line 130.

20. Enter Gross Outpatient Revenue by payor on lines 131 through 139. These amounts are the total outpatient charges, including PPC charges, at the hospital's full established rates for services rendered and goods sold to outpatients during the reporting period. It includes outpatient ambulatory services and outpatient ancillary services. The amounts reported by payor are to be from either the general ledger or payor logs, whichever provides the most accurate data related to the primary payor. On line 140, the HQRS software will enter the sum of lines 131 through 139.

21. Enter the various component amounts of the hospital's Deductions from Revenue for the reporting period on lines 141 through 159. Enter components of deductions from revenue with credit balances as negative amounts (with brackets). Briefly explain in the Comments feature provided by HQRS why a credit balance appears. Complete lines 141 through 159 as follows:

    a. Enter Medicare contractual adjustments on line 141.
    b. Enter Medi-Cal contractual adjustments on line 142.

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c. Enter Disproportionate Share payment adjustments related to Medi-Cal inpatients on line 143. Retroactive Disproportionate Share payments related to prior payment years are to be reported on line 185 as non-operating revenue.
d. Enter County Indigent Programs contractual adjustments on line 145.
Enter Other Third Party Payors contractual adjustments on line 146. For quarters ending March 31, 1997 and later, report Capitation Premium Revenue separately on line 155.
f. Enter Provision for Bad Debts, net of bad debt recoveries, on line 147.
g. Enter Charity - Hill-Burton amounts on line 148.
h. Enter Charity - Other amounts on line 149.
i. Enter Restricted Donations and Subsidies for Indigent Care on line 150.

County hospitals are to report Realignment Funds that do not relate directly to patient care on line 185, Non-Operating Revenue Net of Non-Operating Expenses. Realignment Funds used for specific patients are to be credited against their accounts receivable. Realignment Funds that are used for direct patient care, but not for specific patients, are to be reported on line 145, County Indigent Programs contractual adjustments. In essence, these last two entries reduce the County Indigent Programs - Contractual Adjustments account.

j. U.C. teaching hospitals are to enter Teaching Allowances and Support for Clinical Teaching on lines 151 and 152.

k. For quarters ending March 31, 1997 and later, enter Capitation Premium Revenue on line 155.
l. Enter on line 159 policy discounts, administrative adjustments, and other adjustments and allowances, not specified above.

The HQRS software will enter the sum of lines 141 through 159 on line 160. This is the sum of all deductions from revenue, net of Disproportionate Share Payments, line 143; Restricted Donations and Subsidies for Indigent Care, line 150; and Support for Clinical Teaching, line 152.

Deductions from revenue must be matched against related gross patient revenue within each quarterly reporting period. Most contractual arrangements with purchasers of health care services allow for the reasonable estimation and recording of deductions from revenue when the contractual purchaser is billed. To record deductions from revenue when claims are paid results in a mismatching of deductions from revenue and gross patient revenue,

unless payments for such claims are received within the same reporting period. Prior period cost settlements are to be recorded and reported in the reporting period in which they are paid or received.

Refer to Sections 1400 and 2410.5 of the Manual for more information regarding Charity Care and definitions of the components of deductions from revenue.

22. For calendar quarters ending on or before December 31, 1994, the HQRS software will enter Net Patient Revenue by payor on lines 161 through 169 for the reporting period. Net patient revenue by payor is defined as gross inpatient revenue plus gross outpatient revenue minus related deductions from revenue. Lines 161 through 169 will be completed as follows:

    a. Medicare Net Patient Revenue on line 161 will equal line 121 plus line 131 minus line 141.
    b. Medi-Cal Net Patient Revenue on line 162 will equal line 122 plus line 132 minus the sum of line 142 plus line 143.
    c. County Indigent Programs Net Patient Revenue on line 163 will equal line 123 plus line 133 minus line 145.
    d. Other Third Party Payors Net Patient Revenue on line 164 will equal line 124 plus line 134 minus lines 146 and 147.
    e. Other Payors Net Patient Revenue on line 169 will equal line 129 plus line 139 minus sum of lines 148 through 159.

    The HQRS software will enter the sum of lines 161 through 169 on line 170. Total Net Patient Revenue on line 170 will also equal line 130 plus line 140 minus line 160.

    For calendar quarters beginning on or after January 1, 1995, enter Net Patient Revenue by payor on lines 161 through 169, since the HQRS software will no longer complete these fields. Net patient revenue by payor is defined as gross inpatient revenue plus gross outpatient revenue minus related deductions from revenue. When entering Net Patient Revenue by payor, be sure to apply related bad debts and charity care to that payor category. Enter on line 170 the sum of lines 161 through 169. Total Net Patient Revenue on line 170 must also equal line 130 plus line 140 minus line 160.

23. Enter Other Operating Revenue on line 180. This amount represents revenue related to health care operations, but not from patient care services. Examples include non-patient food sales, rebates and refunds, purchase discounts, supplies and drugs sold to non-patients, Medical Records abstract sales, and Reinsurance Recoveries.
    Section 2410.4 of the Manual provides a detailed list and descriptions of Other Operating Revenue accounts.

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24. Enter Non-operating Revenue Net of Non-operating Expenses on line 185. If non-operating expenses are greater than non-operating revenue, enter the amount as a negative number (with brackets). Non-operating items are those revenue and expenses that do not relate directly to the provision of health care services. Examples include gains and losses on the disposal of assets; income, gains and losses from unrestricted investments; revenue and expenses associated with Medical Office Buildings; and various governmental assessments, taxes, and appropriations.

    See Section 2420.10 of the Manual for a detailed list and descriptions of Non-Operating Revenue and Expense accounts.

25. Enter the amount of Total Capital Expenditures made during the reporting period on line 190. Capital expenditures are defined as all additions to property, plant and equipment, including amounts which have the effect of increasing the capacity, efficiency, lifespan, or economy of operation of an existing capital asset. These are the expenditures recorded under the property, plant and equipment accounts of the balance sheet, and are subject to depreciation or amortization. (Amounts used for acquiring land for hospital operations must be included here although land does not depreciate.)

    Be sure to include all capitalized leases and construction-in-progress in addition to purchased property, plant and equipment. Do not reduce capital expenditures to reflect accrued depreciation expense or the disposal of capital assets; or include capital expenditures associated with Medical Office Buildings.

26. Enter the amount of Fixed Assets Net of Accumulated Depreciation at the end of the reporting period on line 195. Net fixed assets include land, land improvements, buildings and improvements, leasehold improvements, and equipment, less accumulated depreciation and amortization thereon, plus construction-in-progress. Do not include Medical Office Buildings.

27. Line 200, Disproportionate Share Funds transferred to Related Public Entity, relate to county, University of California, and district hospitals only and is an optional reporting item. For applicable hospitals, enter on line 200 the amount of disproportionate share funds transferred or to be transferred to the related public entity for the current quarterly period.

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28. On lines 205 through 220, enter the discharges, patient (census) days, expenses, and gross patient revenue associated with Purchased Inpatient Services. These are optional data items. Purchased Inpatient Services expenses are incurred by the purchasing hospital when inpatient services, including ancillary services, are provided by another hospital for patients who are the responsibility of the purchasing hospital. This situation may arise due to managed care contract requirements or the lack of appropriate medical technology at the facility purchasing the services. If services are purchased under managed care contract requirements, gross patient revenue should be recorded at the same amount as purchased inpatient services expenses in the Other Third Party payor category. Related account receivables may then be written-off to Other Third Party contractual adjustments. See Section 1250 of the Manual for additional information.

29. Enter any comments you may have using the comments feature provided by HQRS, especially if the software has flagged any potential data errors during the validation process, or if there has been a significant change in patient care services since the previously filed report.

    Please note that the HQRS software classifies potential data errors as either Fatal, Critical, or Warning; and that Fatal errors must be resolved before a report can be successfully transmitted by modem. We strongly recommend that you print an Edit Report and review any error messages before officially transmitting your report by modem.

30. The Electronic Quarterly Reporting Certification must be completed by an authorized official of the hospital and sent to the Office before the report has been transmitted by modem. The person signing the certification should be aware of the contents of the report and that the certification is being made under penalty of perjury.

    Transmit the completed report by modem to the Office's BBS. Consult with the User Guide to make sure your modem is set up properly. If you are unable to transmit your report successfully, check the Troubleshooting Section in the User Guide or with your hospital's Technical Support staff.

31. If you have been granted written permission to file a hard-copy report mail the completed report to:

    Office of Statewide Health Planning and Development
    Accounting and Reporting Systems Section
    818 K Street, Room 400
    Sacramento, CA 95814

QUARTERLY REPORTING REQUIREMENTS

For your convenience, you may submit your completed and signed quarterly financial and utilization report by telecopier (FAX No. 916-323-7675). You are not required to submit the original report if it has already been sent by telecopier.

REPORTING FORM 8300

The following is a reproduction of the Quarterly Financial and Utilization Report .

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT

OSHPD Use Only: 1997___ 106_____
Filed Date:_____ PM___ FAX___

1. Facility DBA (Doing Business As) Name:		2. OSHPD Facility No.:
Compliance Medical Center		106599001
3. Street Address:	4. City:	5. Zip Code:
9876 South Inpatient Lane	Forbearance	99099
6. Report Prepared By:		7. Preparer's Phone:
Willie Answer		(203) 123-4567 Ext: 135
8. Chief Executive Officer (Administrator):	9. Main Hospital Phone:	10. Disaster Coordinator's Phone:
O.R. Room	(203) 123-4567	(203) 123-4567 Ext: 911

Line No.	(1) Report Period	Report Due Date	(2) Original (Check One)	(3) Revised (Check One)
15.	January 1 - March 31, 1997	May 15, 1997		
16.	April 1 - June 30, 1997	August 14, 1997	X	
17.	July 1 - September 30, 1997	November 14, 1997		
18.	October 1 - December 31, 1997	February 14, 1998		
19. 20.	Other (Specify: Month/Day/Year) Begin Date: ____/____/____ End Date: ____/____/____	Within 45 days of the end of the corresponding calendar quarter.		
21.	Is this report based on a 13-period accounting cycle?			[ ] Yes [X] No

	UTILIZATION DATA ITEMS	1997 QUARTER
25.	Licensed Beds (end of report period - excluding bassinets and beds in suspense)	375
30.	Available Beds (average for report period - excluding bassinets and beds in suspense)	375
35.	Staffed Beds (average for report period - excluding bassinets and beds in suspense)	300
	Hospital Discharges (excluding nursery discharges)	
41.	Medicare	826
42.	Medi-Cal	1,037
43.	County Indigent Programs	59
44.	Other Third Parties (including Medicare HMO and Medi-Cal HMO discharges)	2,343
49.	Other Payors	52
50.	Total Hospital Discharges (sum of lines 41 thru 49)	4,317
55.	Long-term Care (LTC) Discharges (included in lines 41 - 50) (Optional)**	38
	Patient (Census) Days (excluding nursery patient (census) days)	
61.	Medicare	8,057
62.	Medi-Cal	4,952
63.	County Indigent Programs	178
64.	Other Third Parties (including Medicare HMO and Medi-Cal HMO patient days)	10,531
69.	Other Payors	467
70.	Total Patient (Census) Days (sum of lines 61 thru 69)	24,185
75.	Long-term Care (LTC) Patient Days (included in lines 61 - 70) (Optional)**	2,628
	Outpatient Visits (including ER, Clinic, Referred, Home Health Visits, and Day Care Days)	
81.	Medicare	4,056
82.	Medi-Cal	4,766
83.	County Indigent Programs	177
84.	Other Third Parties (including Medicare HMO and Medi-Cal HMO visits)	12,379
89.	Other Payors	711
90.	Total Outpatient Visits (sum of lines 81 thru 89)	22,089

Continued on Next Page ** The reporting of this item is optional.

QUESTIONS

Please contact us at the following address, phone number, or FAX number:

Patricia Burritt
Office of Statewide Health Planning and Development
Accounting and Reporting Systems Section
818 K Street, Room 400
Sacramento, CA 95814
Phone: (916) 323-0875 FAX No: (916) 323-7675

CERTIFICATION

I, O.R. Room, certify under penalty of perjury that to the best of my knowledge and information, the information reported is true and correct.

By: O.R. Room

Title: Administrator Date: 7/20/97

QUARTERLY REPORT CHECKLIST

For Calendar Quarters Ending on and after March 31, 1996

Even though all hospitals are required to prepare their quarterly report using Office-provided software and to transmit the report by modem to the Office's Bulletin Board System, the following checklist will still assist you in submitting your quarterly report. The focus of this checklist is on those items that are not edited by the reporting software. Use of this checklist may reveal data errors that you can correct before submitting your report, thus eliminating the need for the Office staff to contact you with questions in these areas. Data items should be reasonable and consistent with previously filed reports. If you answer "no" to any of these questions, you should verify the appropriate data items.

_____ 1. Do licensed, available, and staffed beds on lines 25, 30, and 35, respectively, exclude nursery bassinets and beds placed in suspense?

_____ 2. Do hospital discharges (lines 41 through 50) and patient days (lines 61 through 70) exclude nursery discharges and days, and include Long-Term Care discharges and days?

_____ 3. Are hospital discharges (lines 41 through 50) being counted and reported when a formally admitted inpatient: 1) is formally released from the hospital, 2) dies in the hospital, or 3) transfers from one type of care to another type of care within the hospital? There are five types of care: Acute Care, Psychiatric Care, Rehabilitation Care, Long-Term Care, and Residential Care. (See Manual Section 4121 for detailed definition.)

_____ 4. Are patient days (lines 61 through 70) being reported as census days, and not discharge days?

_____ 5. Are all financial and utilization data related to Medicare HMOs and/or Medi-Cal HMOs reported in the Other Third Parties payor category, and not in Medicare and/or Medi-Cal?

_____ 6. Do outpatient visits (lines 81 through 90) include outpatient services related to adult day health care, ambulatory surgery, chemical dependency, clinics, emergency services, home health care, hospice, observation care, partial hospitalization - psychiatric, private referred ancillary services, renal dialysis, and satellite clinics? (See Manual Section 4130 for detailed descriptions of each category.)

_____ 7. Do total operating expenses (line 100) include Physician Professional Component (PPC) expenses and exclude bad debt expense, non-operating expenses, and income taxes? Do not net other operating revenue against operating expenses.

_____ 8. Do inpatient and outpatient gross patient revenue (lines 121 through 140) include PPC charges?

HOSPITAL QUARTERLY FINANCIAL AND UTILIZATION REPORT (Cont'd)

Facility DBA Name: Compliance Medical Center	1997 Quarter Ending: June 30, 1997	OSHPD Facility No.: 106599001

Line No.	FINANCIAL DATA ITEMS	1997 QUARTER
100.	Total Operating Expenses (including PPC expenses reported in line 110)	$ 34,716,572
110.	Physician Professional Component Expenses (PPC)**	$ 450,453
	Gross Inpatient Revenue (including PPC charges)	
121.	Medicare	$ 20,478,005
122.	Medi-Cal	12,298,665
123.	County Indigent Programs	553,985
124.	Other Third Parties (including Medicare HMO and Medi-Cal HMO)	32,069,319
129.	Other Payors	823,487
130.	Total Gross Inpatient Revenue (sum of lines 121 thru 129)	$ 66,223,461
	Gross Outpatient Revenue (including PPC charges)	
131.	Medicare	$ 2,325,805
132.	Medi-Cal	1,613,675
133.	County Indigent Programs	54,332
134.	Other Third Parties (including Medicare HMO and Medi-Cal HMO)	5,389,354
139.	Other Payors	181,232
140.	Total Gross Outpatient Revenue (sum of lines 131 thru 139)	$ 9,564,398
	Deductions from Revenue	
141.	Medicare Contractual Adjustments	$ 16,505,860
142.	Medi-Cal Contractual Adjustments	13,049,445
143.	Disproportionate Share Payments for Medi-Cal Patient Days (SB 855)	(816,648)
145.	County Indigent Programs Contractual Adjustments	164,294
146.	Other Third Parties Contractual Adjustments (excluding capitation premium revenue)	12,706,184
147.	Provision for Bad Debts (including bad debt recoveries)	507,711
148.	Charity - Hill-Burton	
149.	Charity - Other	233,037
150.	Restricted Donations and Subsidies for Indigent Care	( )
151.	Teaching Allowance (for U.C. teaching hospitals only)	
152.	Clinical Teaching Support (for U.C. teaching hospitals only)	( )
155.	Capitation Premium Revenue	( )
159.	Other Adjustments and Allowances	346,388
160.	Total Deductions from Revenue (sum of lines 141 thru 159)	$ 42,696,271
	Net Patient Revenue (Gross Patient Revenue less Deductions from Revenue)	
161.	Medicare	$ 6,290,472
162.	Medi-Cal	1,661,119
163.	County Indigent Programs	415,024
164.	Other Third Parties	24,303,468
169.	Other Payors	421,505
170.	Total Net Patient Revenue (sum of lines 161 thru 169) (Line 130 + line 140 - line 160)	$ 33,091,588
180.	Other Operating Revenue	$ 1,332,257
185.	Nonoperating Revenue Net of Nonoperating Expenses	$ 1,029,900
190.	Total Capital Expenditures (excluding disposal of assets)	$ 2,276,692
195.	Fixed Assets Net of Accumulated Depreciation (including construction-in-progress)	$ 63,328,412
200.	Disproportionate Share Funds Transferred to Related Public Entity**	$
	Purchased Inpatient Services	
205.	Discharges (Not included in lines 41 thru 50)**	
210.	Patient Days (Not included in lines 61 thru 70)**	
215.	Expenses (included in line 100)**	$
220.	Revenue (included in lines 121 thru 130)**	$

** The reporting of this item is optional.

Note: Effective with calendar quarters ended on or after March 31, 1994, all hospitals are required to prepare this quarterly report using the Office-provided Hospital Quarterly Reporting System (HQRS) software and to submit the report by modem to the Office's Bulletin Board System, unless the Office has granted approval in writing to submit this report using this standard report form or the HQRS-produced facsimile report.

Continued on the back of page 2.

QUARTERLY REPORT CHECKLIST (Continued)

_____ 9. Does Provision for Bad Debts (line 147) include all write-offs for that portion of a patient's bill for which the patient is directly responsible, but is uncollectible due to the patient's unwillingness to pay? Include all bad debts on this line, even if the patient is partially covered by a third party payor, such as Medicare.

____ 10. Does Charity - Other (line 149) include only write-offs for that portion of a patient's bill for which the patient is directly responsible, but is uncollectible due to the patient's inability to pay?

_____ 11. Do County Indigent Programs contractual adjustments (line 145) include write-offs for indigent patients whose services were funded in whole or in part by the county?

Note: For county hospitals only, Realignment Funds which are not distributed on a "patient specific" basis for rendered patient care services are to be reported as non-operating revenue on line 185.

_____ 12. Are total Medi-Cal Disproportionate Share payments received or to be received, as provided by Senate Bill (SB) 855, reported on line 143? Report transfers of SB 855 Disproportionate Share payments to a related public entity on line 200.

_____ 13. Is other operating revenue (line 180) reported? Examples include non-patient food sales, rebates and refunds, purchase discounts, supplies and drugs sold to non-patients, and medical records abstract sales.

_____ 14. Is non-operating revenue (line 185) reported net of non-operating expenses? Examples include gains and losses on the disposal of assets; income, gains, and losses from unrestricted investments; revenue and expenses associated with Medical Office Buildings; and various governmental assessments, taxes, and appropriations. If non-operating expenses exceed non-operating revenue, enter the net result as a negative (bracketed) amount.

_____ 15. Do capital expenditures (line 190) include only additions to property, plant, and equipment, including capitalized leases and construction-in-process? Do not reduce by depreciation or disposal of capital assets.

_____ 16. Do this quarter's net fixed assets (line 195) equal last quarter's net fixed assets plus this quarter's capital expenditures (line 190) less this quarter's disposal and depreciation?

_____ 17 Are all financial data items (lines 100 through 200) reported to the nearest dollar?

If there has been any significant change in utilization, patient mix or service mix, please describe in the comments feature provided by the reporting software. Detailed instructions for preparing your quarterly report are included in Chapter 8000 of the *Accounting and Reporting Manual for California Hospitals*, Second Edition.

March 1995